Working Group for Healthcare Innovation
Wednesday November 4, 2015
Meeting Minutes
4:00pm

I. **Welcome & Updates – Secretary of Health & Human Services Elizabeth Roberts**
Secretary Roberts welcomed the group and thanked everyone for coming out this evening. She advised that this is the third full meeting of this Working Group, and the conversations thus far have been very informative and very interesting. She welcomed Anya Rader-Wallack who started work this week as the new Medicaid Director. The Secretary then went through a few slides with an overview of the work done thus far, and the few weeks ahead. The slides were distributed in hard copy, will be available online, and upon request via email to lauren.lapolla@ohhs.ri.gov.

II. **Spending Cap Considerations – Secretary Roberts**
The Secretary discussed a few key questions and considerations underway by Spending Cap Subgroup, and the Working Group overall in the next series of slides.

Discussion:
Neil Steinberg: There is not a standard measurement? When I hear costs have gone up "X" percent nationally that is not compared to Massachusetts? There is not a uniform?
Secretary Roberts: That is probably true, some places often when they talk about costs are talking about premiums. Sometimes costs include long term, sometimes they don't. I think when we commissioned the total cost of care report – did they feel they were using a construct that could be nationally benchmarked?
Cory King: Yes, and they are actually comparing it to the national market scan data (commercial only, not including Medicaid)

Secretary Roberts: Should this be tied to health care spending trends, tied to the state of the economy in RI
Dennis Keefe: I went through this in Massachusetts and there is so much in the details here, academics, research. Going to a cap, does that mean apparent rates of payment are baked in? If so are we baking in any disparities? A lot to consider. I think that it would be good to tie it to the growth of the state's economy. Historical health care growth rate has gotten us where we are.
Pablo Rodriguez: What would happen to Medicaid in a recession, in an economy that is going negative if we have a cap that is tied to economy?
Secretary Roberts: Tying it back – when Dennis said does this bake in where we are, I would argue if we regulate by segment rather than total cost we can be effective – how do we allocate dollars into a cost effective ways. Good question, Dr. Rodriguez; often I feel Medicaid gets cut in a recession anyways, even though it shouldn't; so if we have a recession, do we put in a floor?

John Simmons: What is the correlation between cost of healthcare and the economy?

Secretary Roberts: If you see health care spending as a portion of gross state product, it keeps growing. The intent would be to keep it the same portion and percentage, and grow with the economy.
John Simmons: I am not really comfortable, not sure if cap is appropriate. Distortion of the market- is it all, is it parts – not quite there yet. If I recall in Massachusetts it was a target. Not sure if a hard cap would work. I am not sure if I fully understand all of the consequences of cap as of yet.
Secretary Roberts: The consideration is how do we manage cost effectively and is it the right approach. The question is do people see this as a means of reducing costs effectively? Everyone wants the cost of healthcare to go down, and trying to figure out the levers to do that is what the Governor has asked us to look at. I struggle with what other options are to measure cost over time.

Dennis Keefe: There may be unintended consequences of a hard cap – as such people may feel that population health management is the way to go, as do I. Promising approaches for the future to bend and lower the cost curve going forward. My concern with the hard cap is that it would stifle innovation which would bring us that. I think I would argue for a target then. There is that discussion of the balance.
Stephen Farrell: If healthcare is one of the largest industries in RI economy, I would think we would want to understand the impact of any target that we put on its growth relative to the rest of the economy. Perhaps some actuaries and economists could do some work to get a sense of that. If we do put a target in, we could see what the outcomes might be relative to the cap.

Neil Steinberg: Many in the business community lobby with the notion that if we get healthcare costs down we may get jobs which we had been limited from having due to higher previous costs.
Al Kurose: I think it is important to note that we are trying to blunt a trend that is unsustainable; it seems unlikely to me that anything that disruptive would happen. We want to slow the growth, bend the cost curve, which is important.

Secretary Roberts: Do peoples see other things that we should be doing? Health IT to maximize waste from the system? Primary Care as the partner for individuals navigating the system? What else should we be accelerating or introducing?
Peter Marino: There are opportunities where we have resources but not brought to scale. There are a lot of initiatives in the SIM effort for $20 million dollars; perhaps scale down and do fewer things really well. As we do achieve opportunities, try not to do a little of everything.

Al Kurose: At the alternative pay method meeting at OHIC, we see only 1.5% of the spend in the state is not fee for service. I think that belongs in this discussion. As we talk about Accountable Care Organizations, as we talk about new care delivery and payment models, as long as we are at 98.5%, we are not paying for what we want to get.
Laura Adams: I think actuarial work will help, but I don't think we can understand the

unintended consequences until we put things in place. I don't know that we could predict what we want to – I would encourage getting started with some plan and prepare to be self-correcting.
Peter Andruskiewicz: I really like the first possibility of shared risk compensation models for Accountable Entity models. To me that is what needs to happen. We know we are moving to a future where team based care will be the model; there will be different kinds of models, and they will have to take risk. The faster we can reward those, the faster we will be effective.

Secretary Roberts: Where are the places the state can help to make a cap a success?
David Bromley [sitting in for Jim Roosevelt, Tufts Health Plan]: One of the things we are seeing driving commercial costs are pharmacy costs. Talking about transparency around drug pricing might be an idea.
A. Increasing coverage of preventative services. As a registered dietician, I know that most people have to pay out of pocket; if someone with pre-diabetes saw a dietician it would cost a lot less.
Secretary Roberts: Right, for the state that may be if we want to mandate services, or if we have payers incorporate different models of care in their services.
Dennis Keefe: Often there is not a lot of discussion about incentives and the state could be a leader here. The state could be innovating through their own health plans, and encourage people. Move away from PPO model.
Peter Andruskiewicz: The centralization and rationalization of information. There is one source of truth – look to the Center for Health Information and Analysis (CHIA) in Massachusetts, so that we stop debating the facts and focus on the solutions.

III. **Presentation on Public Health Goals – Director of Health Nicole Alexander-Scott, MD, MPH**
Slides available upon request via email at lauren.lapolla@ohhs.ri.gov, and online.

IV. Group Discussion – Working Group

Lou Giancola: You didn't mention two things, health planning – historically lodged in the Department of Health, the other is the Certificate of Need (CON) and the Conversion Act program. Do you have observations there?
Dr. Alexander-Scott: Yes, so exciting to hear you mention that. The Department of Health was given the charge from a health planning standpoint to develop a statewide inventory so we could figure out what we would put together with SIM, but also considering CON knowing what we have had and where to go. With the most amazing team, we have now in place the compilation of hundreds of hours of statewide health inventory. Many from SIM have heard about the work going into putting that together. Twelve domains assessing our entire system - from primary care providers, to specialty docs, to specialty clinics, to understanding numbers around behavioral health system; also including the patients' perspective. That has been a crucial assessment, and with the hundreds and thousands of

surveys sent out we had a 92% response rate. This will be crucial to our population health plan to lay out over the next year. That will align closely with what this group recommends on the healthcare innovation standpoint. That will also play into our CON work. Stay tuned.

Sam Marullo: Can you speak more about the population health plan?
Dr. Alexander-Scott: Yes, our SIM grant that we received really set out the need and crucial importance of having a statewide population health/behavioral health plan. Our goal is to take all of the tools that we have, compile the data on a state level, and put it together, for a population strategic process for the future. This will incorporate the health inventory I just mentioned, the work of this group, the work of the Reinventing Medicaid working group, and other studies, like the Truvan Behavioral Health Study. We want to take each of those pearls and put together a document and a plan that we can all use to transform our system and change the health outcome dynamic.
Neil Steinberg: In one of the lenses related to cost do we have good data that if we went all in on three items, say obesity, opioid use, etc., we could really contribute to a significant decrease to the cost of healthcare?
Dr. Alexander-Scott: I am not aware of specific data that would speak to that. The great meeting last week in Minnesota really looked at what other states are doing to address cost issues. Making sure reimbursement payments are targeting the right areas to see decreases – million dollar decreases - in payment and in cost. Opportunities to model; the most commonly repeated concern or issue has been behavioral health. I personally wonder if an element of that, is if we talk about obesity, or substance abuse, behavioral health can impact each one of them. It is why I am purposeful about saying we will develop a population health/behavioral health plan.

Sam Salganik: Thank you, this is so important to really think about what we are getting out of the system for the public. Partly to follow upon Neil's comment, there was a paper yesterday in Health Affairs estimating the extra costs associated with obesity related health care conditions. For some of these conditions there are significant cost savings available if we achieve targets. I wonder if there has been thinking about how to incorporate that into the spending cap.

Dr. Alexander-Scott: You well-articulated what I and the Secretary have talked about as we discuss moving from volume to value can we be purposeful in those discussions across the board to see where there are opportunities to have elements which directly impact population health folded into that. There is an in-between that we can work towards: are we reimbursing the provider, community health worker of various types, who can help make that link between what you see in the office to what is happening in the house, and really building momentum at that system level.

Dennis Keefe: Where do you intervene and have a short term impact – trying to boil the ocean. Making an impact in obesity numbers will have good long term effects, but is that realistic with our resources now? Attacking diabetes may have more short term effects that are measurable.

Dr. Alexander-Scott: That is where there are a number of audiences for that discussion. My perspective is that for both diabetes and obesity if we go back to what patients are eating and determining if there is an environment that supports exercise that is critical. But we cannot impact the environment entirely here, need to make that connection with our different audiences. We can talk to them about things like carbohydrate intake, and correct insulin, but if they do not have healthy food in their community to choose from or access to a pharmacy for insulin then it won't help. Need to be mindful of outcomes and all groups.

Paul Larrat: Do you have any specific plans and targets for hepatitis C?
Dr. Alexander-Scott: We are developing a statewide strategic plan, in the final stages of that, looking at surveillance, how to do differently and how to impact treatment. Also recently applied for a grant to be able to be creative in our surveillance component to better understand the treatment components as appropriate. There are cost estimates and mathematical models that we estimate between 13,000 and 17,000 in RI may have hepatitis C, and as I refer to it, that is a tidal wave, as the amount of money it will cost to address that years down the road if we do not tackle it right now will increase substantially.

Al Puerini: When I look at your slides we say 85% do not smoke, but we cannot say 85% of Rhode Islanders eat healthily. And I think we do not spend enough time focusing on that issue. We know those same foods contribute to obesity and diabetes, and I see those develop in too many people. I do not see a huge educational effort out there. Our campaign against cigarette smoke was mostly successful. The state needs to look at a better way of educating the public on what is good to eat and what is bad to eat.
Dr. Alexander-Scott: I accept that. Part of that is a lot of the environments where we see obesity and diabetes are suffering from no access to fruits and vegs, more consumption of processed meats and foods. It is definitely appreciated, we do need to educate, but we also need to make sure that equitable access is available.

Ira Wilson: Can you speculate a bit on analysis and communication of health information? Everyone here knows that we need to make investments in an analytic capacity, and I wonderful if you can share your thoughts on how good we are now, what is the current capacity, and what capacities do we need to grow and expand for the states needs for analysis? The Secretary and her staff did a great job getting data where possible for Reinventing Medicaid, but the biggest issue was there was not a lot of current data available, even if they wanted to give it.
Dr. Alexander-Scott: In terms of how we are doing, there is a tremendous amount of data available in the state – Department of Health, Providence Plan, & other great data sources. A conversation I had today with our Community Health Assessment group is how we take that data to tell the story better. As there is so much that is flying we need to be better about telling the story. We also have a lot of room for improvement in collecting data. For many of these metrics that we have it is the national data as we do not have access to or the mechanism for access to the state data. Much of that is IT restrictions; we are taking basic steps to get to this key data component that we need. On the flip side there are places we have done a better job getting data but we now need to turn it around to tell a story with it.

Rich Glucksman: I would add to that, a lot of investment have been made by the payers and your agency to the All Payer Claims Database (APCD).
Dr. Alexander-Scott: The APCD will be an excellent contribution to that, use it to really drive policy, show how the Patient Centered Medical Homes are doing, etc. Really a matter of processing, telling the story, and getting to action which leads to improving population's health.

Neil Steinberg: Fully understanding and embracing all of this, yet it begs the question for me - what is the percentage of those who do stupid stuff out of choice? The corporate CEO who eats three steaks a week, smokes cigars and drinks, then has a quadruple bypass at age 63 is a big cost to the system too. Do we have a sense for how many are not healthy out of choice? It strikes me that you see a lot of unhealthy behavior by those who have access, but choose not to use it.
Dr. Alexander-Scott: That is a good point; partly I am focusing now on those who really do not have the access, or would want to make the healthy choice but cannot. We want to move those people onto the same level playing field, that health equity concept. Then if you have that equity, I am then all for holding people accountable, myself included, for making smart choices.

Al Kurose: Regarding the APCD, as a power of a health tool – I am not well versed on how the data was agreed to be adopted. I know it will be de-identified, focused on population health. Is there any thought to repurposing that rich resource as well to focus on helping it all run more efficiently. How far can we go on the quality and cost improvement side with that as a resource? Or should it be SIM? Is there a conversation around that, or is it defined?
Dr. Alexander-Scott: The goal really is to have the APCD available and accessible to drive action at a variety of levels. I have been working on putting together our APCD review board. There will be a variety of positions from health insurers to privacy advocates, to community consumer, to hospitals or primary care on this review board with the goal of making this de-identified data useful to see where we can safely use it to benefit goals throughout the state.
Secretary Roberts: I would just add on that we will welcome input from the communities on how to make it valuable and responsive.

Al Charbonneau: Will it be used in line with the way Al Kurose was talking about – cost? This would be a comparison tool so that we could tell high cost providers, low cost?
Secretary Roberts: Yes.
Kathleen Hittner: Just yesterday we were discussing ways to look at specialists, and compare them everywhere. Also in a quality discussion, how many were readmitted to specialists. Look at costs compare costs among providers in our state among other states.
Secretary Roberts: We already have users inside the state trained to use the data, and using it for policy development.

Senator Miller: Legislation on transparency goes to what we are discussing here. There is still a lot of resistance from payers and providers to that type of legislation, so not sure how we tackle that. We had interesting legislative debate on transitions that requiring the spend on public health initiatives, wonder if could be better done if could prioritize what the best public health initiatives are and quality on best spend.

V. Public Comment

No additional comment offered by the public at this time.

VI. Adjourn - Next Full meeting December 1, 2015 at the Department of Administration